Federal Office of Rural Health Policy (FORHP), OAT, has worked with its grantees to develop performance measures to be used to evaluate and monitor the progress of the grantees. Grantee goals are as follows: To improve access to needed services, reduce rural practitioner isolation, improve health system productivity and efficiency, and improve patient outcomes. In each of these categories, specific indicators were designed and are reported through a performance monitoring Web site. These measures cover the principal topic areas of interest to FORHP. The data are used for program improvement and grantees use the data for performance tracking and improvement. Revisions include minor additions to the OAT Performance Improvement Measurement System (PIMS) to capture minimal data on access to care, population demographics, insurance status, quality improvement and clinical measures.

Likely Respondents: Telehealth Network Grantees.

Burden Statement: Burden in this context means the time expended by persons to generate, maintain, retain, disclose or provide the information requested. This includes the time needed to review instructions; to develop, acquire, install and utilize technology and systems for the purpose of collecting, validating and verifying information, processing and maintaining information, and disclosing and providing information; to train personnel and to be able to respond to a collection of information; to search data sources; to complete and review the collection of information; and to transmit or otherwise disclose the information. The total annual burden hours estimated for this ICR are summarized in the table below.

TOTAL ESTIMATED ANNUALIZED BURDEN—HOURS

Form name	Number of respondents	Number of responses per respondent	Total responses	Average burden per response (in hours)	Total burden hours
PIMS	200	2	400	7	2,800
Total	200		400		2,800

Jason E. Bennett,

Director, Division of the Executive Secretariat.

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BILLING CODE 4165–15–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Resources and Services Administration

Agency Information Collection Activities: Proposed Collection: Public Comment Request; Ryan White HIV/AIDS Program Core Medical Services Waiver Application Requirements

AGENCY: Health Resources and Services Administration (HRSA), Department of Health and Human Services.

ACTION: Notice.

SUMMARY: In compliance with the requirement for opportunity for public comment on proposed data collection projects (Section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995), HRSA announces plans to submit an Information Collection Request (ICR), described below, to the Office of Management and Budget (OMB). Prior to submitting the ICR to OMB, HRSA seeks comments from the public regarding the burden estimate, below, or any other aspect of the ICR.

DATES: Comments on this ICR should be received no later than January 3, 2017.

ADDRESSES: Submit your comments to *paperwork@hrsa.gov* or mail the HRSA Information Collection Clearance Officer, Room 14N39, 5600 Fishers Lane, Rockville, MD 20857.

FOR FURTHER INFORMATION CONTACT: To request more information on the proposed project or to obtain a copy of the data collection plans and draft instruments, email *paperwork@hrsa.gov* or call the HRSA Information Collection Clearance Officer at (301) 443–1984.

SUPPLEMENTARY INFORMATION: When submitting comments or requesting information, please include the information request collection title for reference.

Information Collection Request Title: Ryan White HIV/AIDS Program Core Medical Services Waiver Application Requirements.

OMB No. 0915–0307—Extension.

Abstract: Title XXVI of the Public Health Service (PHS) Act, as amended by the Ryan White HIV/AIDS Treatment Extension Act of 2009 (Ryan White HIV/AIDS Program), Part A section 2604(c), Part B section 2612(b), and Part C section 2651(c), requires that grantees expend 75 percent of Parts A, B, and C funds on core medical services, including antiretroviral drugs for individuals with HIV, identified and eligible under the legislation. For grantees under Parts A, B, and C to be exempted from the 75 percent core medical services requirement, they must request and receive a waiver from HRSA, as required in the Act.

On October 25, 2013, HRSA published revised standards for core medical services waiver requests in the **Federal Register** (78 FR 63990). These revised standards allow grant recipients flexibility to adjust resource allocation based on the current situation in their local environment. These standards ensure that grant recipients receiving waivers demonstrate the availability of core medical services, including antiretroviral drugs, for persons with HIV served under Title XXVI of the PHS Act. The core medical services waiver uniform standard and waiver request process will apply to Ryan White HIV/AIDS Program Grant Awards under Parts A, B, and C of Title XXVI of the PHS Act. Core medical services waivers will be effective for a 1-year period that is consistent with the grant recipient award period. Grant recipients may submit a waiver request before the annual grant application, with the application, or up to 4 months after the grant recipient award has been made.

Need and Proposed Use of the Information: HRSA uses the documentation submitted in core medical services waiver requests to determine if the applicant/grant recipient meets the statutory requirements for waiver eligibility including: (1) No waiting lists for AIDS Drug Assistance Program services; and (2) evidence of core medical services availability within the grant recipient's jurisdiction, state, or service area to all individuals with HIV identified and eligible under Title XXVI of the PHS Act. See sections 2604(c)(2), 2612(b)(2), and 2651(c)(2) of the PHS Act.

Likely Respondents: Ryan White HIV/AIDS Program Part A, B, and C grant recipients.

Burden Statement: Burden in this context means the time expended by persons to generate, maintain, retain, disclose or provide the information requested. This includes the time needed to review instructions; to develop, acquire, install and utilize technology and systems for the purpose of collecting, validating and verifying information, processing and maintaining information, and disclosing and providing information; to train personnel and to be able to respond to a collection of information; to search data sources; to complete and review the collection of information; and to transmit or otherwise disclose the information. The total annual burden hours estimated for this ICR are summarized in the table below.

Total Estimated Annualized burden hours:

Form name	Number of respondents	Number of responses per respondent	Total responses	Average burden per response (in hours)	Total burden hours
Waiver Request	20	1	20	5.5	110
Total	20	1	20	5.5	110

HRSA specifically requests comments on (1) the necessity and utility of the proposed information collection for the proper performance of the agency's functions, (2) the accuracy of the estimated burden, (3) ways to enhance the quality, utility, and clarity of the information to be collected, and (4) the use of automated collection techniques or other forms of information technology to minimize the information collection burden.

Jason E. Bennett,

Director, Division of the Executive Secretariat.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Indian Health Service

Organization and Functional Statement; Part GFG; California Area Office; Proposed Functional Statement

Part G, of the Statement of Organization, Functions, and Delegations of Authority of the Department of Health and Human Services (HHS), as amended most recently at 63 FR 1486, January 9, 1998, is hereby amended to reflect a realignment of the California Area Indian Health Service.

The California Area Indian Health Service (CAIHS) provides the healthcare delivery system to the State of California, the home of the largest population of American Indians/Alaska Natives (AI/AN) in the country. According to the 2010 Census, California's Indian population was 333,346 in 2010. The 2010 Census also indicated that there were 294,216 additional people who stated that they were American Indian and a combination of one or more other races. California is home to 107 Federally-recognized Tribes. There are presently 31 California Tribal health programs operating 57 ambulatory clinics under the authority of the Indian Self-Determination Act. The IHS funds ten California Area urban health programs that operate under the authority of the Indian Health Care Improvement Act. In fiscal year 2014, California Tribal health programs had 119,362 registered users and 69,238 active users. Registered users are a cumulative total for all Indian patients ever seen at Tribal facilities, and active users are those that have accessed care during the past three years. None of the Tribal facilities and programs currently operating in California originated as facilities previously operated by the IHS, as is the case in other IHS areas. Population sizes and dispersion of Tribal groups in the CAIHS makes it unlikely that a hospital-based service program will develop within the area, similar to other IHS areas where the Federal government has built, staffed and maintained hospitals and satellite clinics on Indian reservations. Tribal programs will continue to rely on private and public hospitals to meet inpatient and emergency needs. Some Tribal health program physicians have privileges at local hospitals and follow their patients through the local hospital system. Otherwise, the patients are referred to private physicians using Purchased Referred Care (PRC) funding, as well as other alternate resources. Most programs have not developed laboratory, pharmacy or x-ray specialties, so these services are purchased from the private sector through PRC funding or other Tribal resources. The CAIHS is proposed to be organized as follows:

Office of the Area Director (GFGA)

Provides overall direction and leadership for the CAIHS by: (1) Encouraging maximum consultation and participation by California area Tribes and Tribal and urban Indian organizations in establishing the goals, objectives and development of policies of the CAIHS; (2) coordinating the CAIHS activities and resources internally and externally with those of other Federal, state, local and privately funded health care programs to maximize quality health care services to Tribal and urban Indians in the State of California; (3) ensuring compliance to the IHS guidelines and administrative procedures pertinent to Indian self-determination contracting processes and Tribal self-governance compacting; (4) assuring that Indian Tribes and Indian organizations are informed regarding pertinent health policy and program management issues and coordinates meetings and other communications with Tribal delegations; (5) advocating for the health needs and concerns of AI/AN; (6) developing and demonstrating methods and techniques for continuous improvement of health services management and delivery by California area Tribes and Tribal and urban Indian organizations; (7) ensuring that the principles of Equal Employment Opportunity laws and the Civil Rights Act are applied in the management of the human resources of the CAIHS; (8) advising the Director, IHS, of issues and potential issues, relevant to the California area, or to the IHS in general, and recommending and participating in actions to prevent or correct problems; (9) providing leadership for the development of emergency preparedness plans, policies, and services, including the continuity of operations plans, deployment, public health infrastructure, and emergency medical services for the CAIHS responsibilities; and (10) advocating and coordinating support for Tribal emergency medical services programs, including training and equipment.